

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

5655

MARYLAND STATE DEPARTMENT OF HEALTH

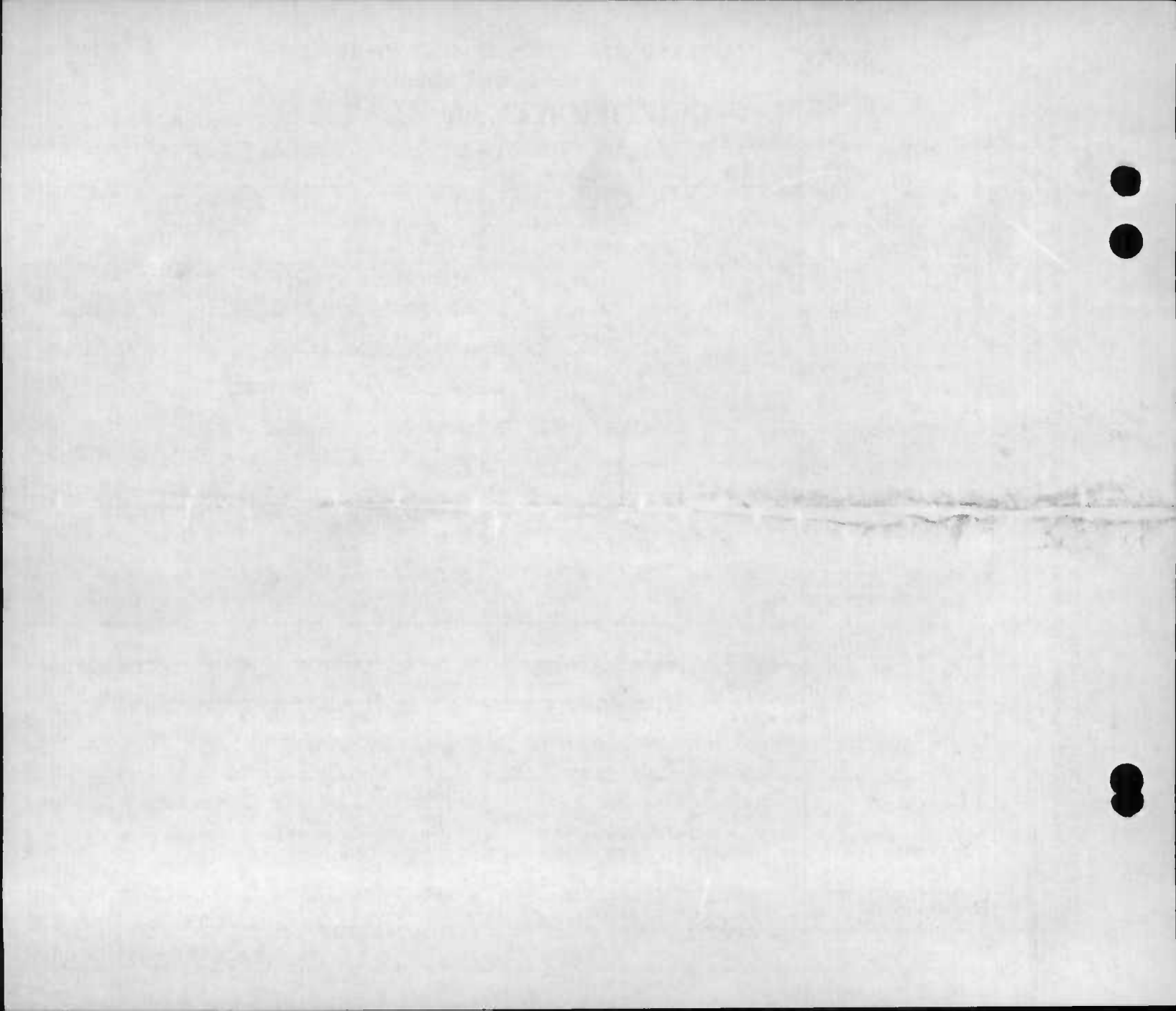
2411 N. Charles Street, Baltimore

05664

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY <u>Howard Co.</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Md.</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Ellicott City</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Balto City</u> 3 Vol-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Schoffer Convelecent Home</u>		STREET ADDRESS (If rural, give location) <u>1409 Cherry St.</u> ✓	
3. NAME OF DECEASED (Type or Print) <u>JOSEPHINE</u> (First) (Middle) (Last)		4. DATE OF DEATH <u>BALONIS</u> (Month) (Day) (Year) <u>June 22 1955</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>May 10, 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days Hours Min.
11. BIRTHPLACE (State or foreign country) <u>Poland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jacob Grocki</u>		14. MOTHER'S MAIDEN NAME <u>Boranski</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Joseph Balonis 604 Washburn Ave</u>			
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
443X Immediate cause (a) <u>Baricard Hemorrhage</u>			<u>acute</u>
Antecedent cause(s) Disease or conditions, if any, giving rise to the above cause stating the underlying cause last (b) <u>Hypertensive C.V. disease</u>			<u>3 yrs</u>
(c)			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>June 17, 1955</u> , to <u>June 22, 1955</u> , that I last saw the deceased alive on <u>June 22, 1955</u> , and that death occurred at <u>9A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>J. A. Norton</u>		ADDRESS <u>Ellicott City Md.</u> DATE SIGNED <u>6/23/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>6/27/1955</u>	
NAME OF CEMETERY OR CREMATORY <u>Holy Cross</u>		LOCATION (City, town, or county) (State) <u>A.A. Co. Md.</u>	
DATE REC'D BY LOCAL REG. <u>6-28-55</u>		REGISTERAR'S SIGNATURE <u>C. A. Hedrick</u>	
24. FUNERAL DIRECTOR <u>Wm. S. Fialkowski</u>		ADDRESS <u>2007 Eastern Ave</u>	



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

5656

05665

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH- COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md</u> COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>BALTIMORE</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>R.F.D. & ELlicott City</u>		STREET ADDRESS (If rural, give location) <u>2711 HURON ST</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>EVA</u> (Middle) <u>A.</u> (Last) <u>BERTHOLD</u>		4. DATE OF DEATH (Month) <u>JUNE</u> (Day) <u>10</u> (Year) <u>1953</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>JAN 16 - 1892</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Wife</u>		10b. KIND OF BUSINESS OR INDUSTRY	9. AGE last birthday <u>63</u> yrs. If under 1 year Months Days If under 24 hrs. Hours Min.
11. FATHER'S NAME <u>Julius Wieprecht</u>		12. CITIZEN OF WHAT COUNTRY?	
13. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)		14. MOTHER'S MAIDEN NAME <u>—</u>	
15. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT AND ADDRESS <u>CHARLES E. BERTHOLD 2711 HURON ST</u>	
18. MEDICAL CERTIFICATION			
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			INTERVAL BETWEEN ONSET AND DEATH
174X Immediate cause (a) <u>Cardiac Failure</u>			<u>Immediate</u>
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Carcinoma of Uterus</u>			<u>18 months</u>
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>3/3/55</u> , to <u>6/10/55</u> , that I last saw the deceased alive on <u>6/10/55</u> , and that death occurred at <u>11:30 P</u> m., from the causes and on the date stated above.			
SIGNATURE <u>William F. Hearnway M.D.</u>		ADDRESS <u>Whitt Ct., Md.</u> DATE SIGNED <u>6/10/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF	NAME OF CEMETERY OR CREMATORY	LOCATION (City, town, or county) (State)
<u>130 King</u>	<u>6-14-1955</u>	<u>Raydon Park</u>	<u>Balto Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR	ADDRESS
<u>6-13-55</u>	<u>W. Redwood</u>	<u>Port Co B.M. Walters</u>	<u>PRATT & STRICKER STS</u>



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist.

No.

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (In this place)		CITY (If outside corporate limits write RURAL and give nearest town)		OR TOWN	
TOWN <u>Ellicott City, Md.</u>		<u>1yr</u>		TOWN <u>Baltimore</u>		<u>3V01-4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		<u>Schaffers Nursing Home</u>		STREET ADDRESS (If rural, give location)		<u>107 E. 25 TH. ST</u>	
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>DANIEL</u>		<u>CAMPBELL</u>		<u>June 7</u>		<u>19 55</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>male</u>	<u>white</u>	<u>widowed</u>	<u>1-8-1871</u>	<u>84</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>OWNER</u>		<u>LUMBERMILL</u>		<u>Maryland</u>			
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>unknown</u>				<u>unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>no</u>		<u>NONE</u>		<u>Preston S. Campbell 107 E. 25 ST. Balto. Md.</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:				INTERVAL BETWEEN ONSET AND DEATH			
<u>420.1</u>				<u>Coronary Thrombosis</u>			
Immediate cause (a)..... DUE TO				<u>2 1/2 hours</u>			
Antecedent cause(s) (b)..... DUE TO							
Diseases or conditions, if any, giving rise to the above cause stating underlying cause last (c)							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>none</u>							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:			
<u>none</u>				<u>—</u>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)		20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
M.							
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Grayce E. Burdette</u>		<u>6-9-55</u>		<u>Moreland Memorial Park</u>		<u>Balto. Md.</u>	
23. BURIAL, CREMATION, REMOVAL (Specify):		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>Burial</u>		<u>John B. Langhan</u>		<u>F.C. Higinbotham</u>		<u>Ellicott City, Md.</u>	
DATE REC'D BY LOCAL REG.							
<u>6. 9. 55</u>							

05666

BUREAU V. S.

JUN 13 1955

RECEIVED

5653

CERTIFICATE OF DEATH

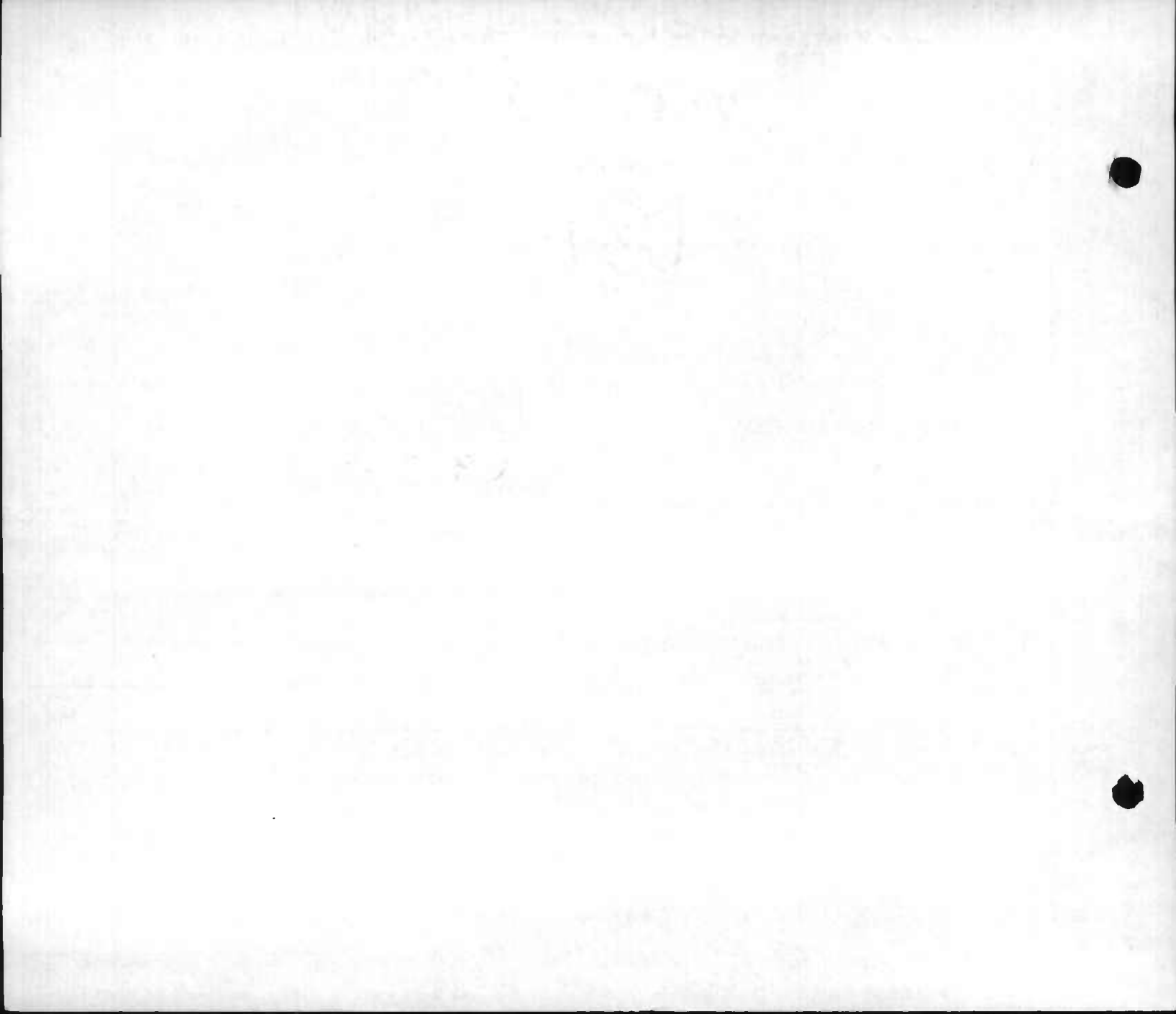
Reg. Dist. No. 196

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Howard County</i>	MARYLAND	STATE <i>Maryland</i>	COUNTY <i>Baltimore</i>
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Ellicott City</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) <i>Pikesville</i>	03X-2
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sheaffer Counseling Center</i>		STREET ADDRESS (if rural give location) <i>Sudbrook Ave.</i>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE (Month) (Day) (Year)	
<i>Margaret Barron Clark</i>		DATE OF DEATH: <i>June 21</i> 19 <i>55</i>	
5. SEX: <i>Female</i>	6. COLOR OR RACE: <i>White</i>	7. SINGLE, MARRIED, WIDOWED, OR DIVORCED: <i>Widowed</i>	8. DATE OF BIRTH: <i>2-8-1866</i>
9. AGE last birthday <i>89</i> yrs.		10. MONTHS <i>21</i> DAYS <i>19</i> HOURS <i>55</i> MIN.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>Housewife</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Edward Barron</i>		14. MOTHER'S MAIDEN NAME: <i>Mary Kilcommons</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <i>No</i>		16. SOCIAL SECURITY NO. <i>None</i>	
17. INFORMANT & ADDRESS: <i>Balto. Co. Welfare Dept. Towson, Md.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE (A) <i>Interventricular CV disease</i>			10 yrs -
ANTECEDENT CAUSE (B)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <i>June 21, 1954</i> , to <i>June 21, 1955</i> , that I last saw the deceased alive on <i>June 21, 1955</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>E. A. Peterson</i>		ADDRESS <i>Ellicott City</i> DATE SIGNED <i>6-23-55</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>6/23/55</i>	
NAME OF CEMETERY OR CREMATORY <i>Princedale</i>		LOCATION (City, town, or county) (State) <i>Pikesville 8. Md.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>6-23-55</i>		REGISTRAR'S SIGNATURE <i>R. W. Hedrick</i>	
24. FUNERAL DIRECTOR <i>Charles H. Howard</i>		ADDRESS <i>Pikesville</i>	

MARGIN RESERVED FOR BINDING

VS. A15 — 10 - 53

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



CERTIFICATE OF DEATH

Reg. Dist. No. ... / 9 / ...

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Howard</u>		MARYLAND		STATE <u>md</u>		COUNTY <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Mariottville</u> 03X-2			
X TOWN <u>Ellicott City</u>				STREET ADDRESS (If rural give location)			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>90 Wheeler Nursing Retreat</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Louis</u> <u>Chauss</u>				<u>June</u> <u>18</u> <u>1955</u>			
5. SEX: <u>M</u>	6. COLOR OR RACE: <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>12-30-1861</u>	9. AGE last birthday <u>94</u> yrs.	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Farmer</u>				10B. KIND OF BUSINESS OR INDUSTRY: <u>Agriculture</u>	11. BIRTHPLACE (State or foreign country): <u>France</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME: <u>Unknown</u>				14. MOTHER'S MAIDEN NAME: <u>Unknown</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT & ADDRESS: <u>Mr. George Chauss. Mariottville, md.</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
IMMEDIATE CAUSE <u>177X</u>							
ANTECEDENT CAUSE (S) <u>Carcinoma of Ovary with metastases</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.						2 yrs.	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:		19B. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>6-16</u> , 19 <u>55</u> , to <u>6-18</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6-17, 1955</u> , and that death occurred at <u>12:15 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>John B. Longman</u>				DATE SIGNED <u>June 20, 1955</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>6-21-55</u>		<u>Wards Chapel</u>		<u>Baltimore Co., md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>6-20-1955</u>		<u>John B. Longman</u>		<u>Arthur H. Haight</u>		<u>Hydenville, md.</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 24 1955

RECEIVED

5660

CERTIFICATE OF DEATH

Reg. Dist. No. 195

Film 6123 7-7-55 et

1. PLACE OF DEATH:

COUNTY

Howard

MARYLAND

CITY (If outside corporate limits, write RURAL LENGTH OF STAY
OR and give nearest town) (in this place)TOWN
X Laurel (Rural)
HOSPITAL OR
INSTITUTION OR
STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Md

COUNTY

Howard

CITY (If outside corporate limits, write RURAL and give nearest town)
OR
TOWNLaurel (Rural)
STREET ADDRESS
(If rural give location)3. NAME OF
DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

Margaret

Elizabeth

Dill

4. DATE
OF
DEATH:

(Month)

(Day)

(Year)

June

1

19 55

5. SEX:

6. COLOR OR
RACE:7. SINGLE, MARRIED,
WIDOWED, DIVORCED,
(Specify):

8. DATE OF BIRTH:

9. AGE last birthday: IF UNDER 1 YEAR IF UNDER 24 HRS.

2

W

Widowed

Unknown

70?

yrs.

Months

Days

Hours

Min.

10a. USUAL OCCUPATION. Give kind of
work done during most of working life,
even if retired):10b. KIND OF BUSINESS OR
INDUSTRY:

11. BIRTHPLACE (State or foreign country):

12. CITIZEN OF WHAT
COUNTRY?

13. FATHER'S NAME:

14. MOTHER'S MAIDEN NAME:

15. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unk.) (If Yes, give war or dates of
service)

16. SOCIAL SECURITY No.:

17. INFORMANT & ADDRESS:

9

422.1

Unknown

Unknown

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Interval Between
Onset And Death

Immediate cause

(a) DUE TO

Antecedent causes (s)

Diseases or conditions, if any,
giving rise to the above cause
stating the underlying cause last.

(b) DUE TO

(c)

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not
related to the disease or condition causing death.

19a. DATE OF OPERATION:

19b. MAJOR FINDINGS OF OPERATION

20. AUTOPSY ?

Yes ☐ No ☐21. ACCIDENT
SUICIDE
HOMICIDE

(Specify)

PLACE (Home, farm, factory, street,
OF office bldg., etc.)
INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour)
OF INJURY m.INJURY OCCURRED
While at Not While
Work ☐ At Work ☐

HOW DID INJURY OCCUR ?

22. I hereby certify that I attended the deceased from 5/15, 1955, to 6-1, 1955, that I last saw the deceased

alive on 6-1, 1955, and that death occurred at 8 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION,
REMOVAL (Specify)

DATE THEREOF

NAME OF CEMETERY OR CREMATORY

LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL
REGISTRAR

REGISTRAR'S SIGNATURE

24. FUNERAL DIRECTOR

ADDRESS

June 29, 1955

Dr. Frank P. Weaver

The Anatomy Board

MD

sub: M. Christian

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 29 1955

RECEIVED

MARYLAND 5661

05672
STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 193

1. PLACE OF DEATH: COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u> TOWN <u>Cooksville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS		2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>Md.</u> COUNTY <u>Howard</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>Cooksville</u> TOWN <u>Cooksville</u> STREET ADDRESS (If rural, give location) <u>1</u>	
3. NAME OF DECEASED (Type or Print) (First) <u>LOUIS</u> (Middle) <u>WILLIAM HENRY</u> (Last) <u>FRANCE</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>16</u> (Year) <u>1955</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>Col.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widowed</u>	8. DATE OF BIRTH <u>9-6-1890</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Harmon</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Harmon Co.</u>	9. AGE last birthday <u>64</u> yrs.
11. BIRTHPLACE (State or foreign country) <u>Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Louis W. H. France</u>		14. MOTHER'S MAIDEN NAME <u>Lusie Hammond</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY No. <u>705-12-2675</u>	
17. INFORMANT AND ADDRESS <u>M. Albert France, Cooksville, Md.</u>			

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
<p>443X Immediate cause (a) <u>Cardiac arrest, by pericardium,</u></p> <p>Antecedent cause(s) (b) <u>Arteriosclerosis, uremia, left</u></p> <p>Diseases or conditions, if any, giving rise to the above cause, stating the underlying cause last (c) <u>hepatic failure.</u></p>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
19a. DATE OF OPERATION <u>0</u>	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from <u>Oct</u> , 19 <u>54</u> , to <u>June</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>16 June</u> , 19 <u>55</u> , and that death occurred at <u>7:15 P.M.</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Howard E. Hall</u> (Degree or title) <u>MD</u>		ADDRESS <u>Sequerville, Md</u> DATE SIGNED <u>16 June 55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE	NAME OF CEMETERY OR CREMATOR	LOCATION (City, town, or county) (State)
<u>Burial</u>	<u>6-19-55</u>	<u>Brown & France Family</u>	<u>Cooksville, Md</u>
DATE REC'D BY LOCAL REG.	REGISTRAR'S SIGNATURE	24. FUNERAL DIRECTOR ADDRESS	
<u>June 18, 1955</u>	<u>C. Pearl Musier</u>	<u>Walter H. Haight, Sequerville, Md.</u>	

MARGIN RESERVED FOR BINDING

These were lost - I just found them

RECEIVED

JUL

BUREAU V. S.

05673

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

5662

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH - COUNTY Howard		MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED - STATE Maryland		COUNTY Carroll	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		LENGTH OF STAY (in this place) 6 weeks		CITY (If outside corporate limits, write RURAL and give nearest town) Mt. Airy		06X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS 00				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print) ROSENE		(First)		(Middle) MULLINIX		(Last)	
4. DATE OF DEATH JUNE 19, 1955		(Month)		(Day)		(Year)	
5. SEX female		6. COLOR OR RACE white		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed		8. DATE OF BIRTH 10-9-1865	
9. AGE last birthday 89 yrs.		If under 1 year Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife		10b. KIND OF BUSINESS OR INDUSTRY own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT U.S.A.		13. FATHER'S NAME William Merson		14. MOTHER'S MAIDEN NAME Louise ?	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) no		16. SOCIAL SECURITY No. none		17. INFORMANT AND ADDRESS Guerney Mullinix, Mt. Airy, Md.			
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) Coronary occlusion						acute	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (b) Arteriosclerotic C.V. disease						20 yrs -	
(c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>							
21. ACCIDENT (Specify) SUICIDE HOMICIDE		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from May 1, 1955 , to June 19, 1955 , that I last saw the deceased alive on June 18, 1955 , and that death occurred at 8 A.M. , from the causes and on the date stated above.							
SIGNATURE John B. Loughran				ADDRESS Ellicott City		DATE SIGNED 6/20/55	
23. BURIAL, CREMATION REMOVAL (Specify) BURIAL		DATE THEREOF 6-21-1955		NAME OF CEMETERY OR CREMATORY Montgomery Chapel		LOCATION (City, town, or county) (State) Montg. Co., Maryland	
DATE REC'D BY LOCAL REG. 6-20-55		REGISTRAR'S SIGNATURE John B. Loughran		24. FUNERAL DIRECTOR C. M. Waltz		ADDRESS Winfield, Maryland	

VS. A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The object age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 24 1955

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

05674

5663

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 194

1. PLACE OF DEATH COUNTY <u>Howard</u>		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>Howard</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>	
TOWN <u>Highland</u>		TOWN <u>Highland</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (If rural, give location)	
3. NAME OF DECEASED (Type or Print) <u>William Lee Rannick</u>		4. DATE OF DEATH (Month) <u>June</u> (Day) <u>7</u> (Year) <u>1955</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>11/5/1889</u>
9. AGE last birthday <u>65</u> yrs.		10. AGE last birthday If under 1 year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Merchant</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Retail Store</u>	
11. BIRTHPLACE (State or foreign country) <u>Montgomery, Ala.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Henry Rannick</u>		14. MOTHER'S MAIDEN NAME <u>Leathem Anchia Saitter</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY No. <u>219-32-1034</u>	
17. INFORMANT AND ADDRESS <u>Miss Ada E. Rannick</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
420.1 Immediate cause (a) <u>Coronary Embolus</u>		<u>1 hr.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>Coronary Arteriosclerosis</u>		<u>2 yr.</u>	
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Nov</u> , 19 <u>53</u> , to <u>June 7</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>June 7</u> , 19 <u>55</u> , and that death occurred at <u>9 A</u> m., from the causes and on the date stated above.			
SIGNATURE <u>Robert S. McConney Jr.</u>		ADDRESS <u>402 Main St Laurel Md</u>	
DATE SIGNED <u>6/2/55</u>			
23. BURIAL, CREMATION REMOVAL (Specify) <u>burial</u>		DATE THEREOF <u>6-10-55</u>	
NAME OF CEMETERY OR CREMATORY <u>St. Louis</u>		LOCATION (City, town, or county) <u>Clarksville, Md.</u>	
24. FUNERAL DIRECTOR <u>F.C. Higinbotham</u>		ADDRESS <u>Ellicott City, Md.</u>	
DATE REC'D BY LOCAL REG. <u>June 8 1955</u>		REGISTRAR'S SIGNATURE <u>Marie A. Whitaker</u>	

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

BUREAU V. S.

JUN 13 1955

RECEIVED

MARYLAND

5664

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 195

1. PLACE OF DEATH COUNTY <u>Lanard</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Florida</u> COUNTY <u>Pinellas</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Petersburg</u> LENGTH OF STAY (in this place) <u>6 days</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>St. Petersburg</u> 48X-3	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Balt. Wash. Blvd.</u>		STREET ADDRESS (If rural, give location) <u>617 27th Ave. N.</u>	
3. NAME OF DECEASED (First) <u>Maud</u> (Middle) <u>Griffith</u> (Last) <u>Ranahaw</u>	4. DATE OF DEATH (Month) <u>June</u> (Day) <u>6</u> (Year) <u>1955</u>		
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>married</u>	8. DATE OF BIRTH <u>July 4, 1883</u>
9. AGE last birthday <u>71</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>housewife</u>	10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>	11. BIRTHPLACE (State or foreign country) <u>Winchester, Kentucky</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	13. FATHER'S NAME <u>Joshua Griffith</u>	14. MOTHER'S MAIDEN NAME <u>Serelda Cobb</u>	15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)
16. SOCIAL SECURITY No.	17. INFORMANT AND ADDRESS <u>Wm. J. Ranahaw St. Petersburg Fla</u>		

18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		
420.1 Immediate cause (a) <u>Acute Coronary Occlusion</u>		10 min.
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last		
(b) <u>Arteriosclerosis, moderate with</u>		
(c) <u>Coronary Insufficiency</u>		
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.		
<u>Old myocardial infarction (2)</u>		15 yrs.
19a. DATE OF OPERATION <u>None</u>	19b. MAJOR FINDINGS OF OPERATION <u>None</u>	20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>None</u>	PLACE (Home, farm, factory, street, or office block, etc.) <u>None</u>	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>None</u>	INJURY OCCURRED While at <input checked="" type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>None</u>

22. I hereby certify that I attended the deceased from 6/2, 1955, to 6/6, 1955, that I last saw the deceased alive on 6/6/55, 1955, and that death occurred at 1:00 P m., from the causes and on the date stated above.

SIGNATURE R. L. Erickson M.D. (Degree or title) ADDRESS Laurel, Maryland DATE SIGNED 6/6/55

23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE <u>June 9, 1955</u>	NAME OF CEMETERY OR CREMATORY <u>Highland Cemetery</u>	LOCATION (City, town, or county) (State) <u>Conington, Kentucky</u>
DATE REC'D BY LOCAL REC. <u>June 7-55</u>	REGISTRAR'S SIGNATURE <u>Frank Shipley</u>	24. FUNERAL DIRECTOR <u>De Witt Davidson</u>	ADDRESS <u>Laurel, Md</u>

MARGIN RESERVED FOR BINDING

BUREAU V. S.

JUN 13 1955

RECEIVED

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

05676

5665

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Howard</u>	MARYLAND	STATE <u>Md.</u>	COUNTY
CITY (If outside corporate limits, write RURAL and give nearest town) <u>X</u> TOWN	LENGTH OF STAY (In this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>2746 Guilford Ave</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Hilltop Monn Nursing Home</u>		STREET ADDRESS (If rural give location) <u>Baltimore, Md</u> <u>3401-4</u>	
3. NAME OF DECEASED: (First) (Middle) (Last) <u>Gertrude Lee Thomas</u>		4. DATE (Month) (Day) (Year) OF DEATH: <u>June 24 1955</u>	
5. SEX: <u>Female</u>	6. COLOR OR RACE: <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, <u>Widowed</u>	8. DATE OF BIRTH: <u>Dec 8, 1869</u>
9. AGE last birthday <u>85</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <u>Housewife</u>		10B. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
11. BIRTHPLACE (State or foreign country): <u>Norfolk Va.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME: <u>Richard W. Lee</u>		14. MOTHER'S MAIDEN NAME: <u>Grace Starvo</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.): <u>9</u> (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT & ADDRESS: <u>Ronney L. Thomas 2746 Guilford Ave</u>			
18. MEDICAL CERTIFICATION		INTERVAL BETWEEN ONSET AND DEATH	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
334X IMMEDIATE CAUSE		(A) <u>Cerebral & Generalized Arteriosclerosis</u>	
ANTECEDENT CAUSE (S)		(B)	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		(C)	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Asthma of Spine & Knees</u>			
19A. DATE OF OPERATION: <u>0</u>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. TIME (Month) (Day) (Year) (Hour) OF INJURY	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>5/25</u> , 19 <u>55</u> , to <u>6/24</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>6/22</u> , 19 <u>55</u> , and that death occurred at <u>5:30</u> P. M. from the causes and on the date stated above.			
SIGNATURE <u>Wm J. Willy</u>		ADDRESS <u>5226 Balt. Nat. Bldg</u> DATE SIGNED <u>6/24/55</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>June 27-1955</u> <u>Moulton</u>		<u>Baltimore Md</u>	
DATE REC'D BY LOCAL REGISTRAR		24. FUNERAL DIRECTOR ADDRESS	
<u>27-55</u> <u>Wm Cook Inc</u>		<u>1217 St Paul St</u>	

100

05678

MARYLAND

STATE DEPARTMENT OF HEALTH

5666

CERTIFICATE OF DEATH

Reg. Dist. No. 191

1. PLACE OF DEATH COUNTY Howard MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE Md. COUNTY	
CITY (If outside corporate limits, write RURAL and give nearest town) Ellicott City		CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore 3401-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS Scheaffers Retreat Montgomery Road		STREET ADDRESS (If rural, give location) 4213 Connecticut Ave. ✓	
3. NAME OF DECEASED (Type or Print) Mary or Mamie R. Williams		4. DATE OF DEATH (Month) June (Day) 25 (Year) 1955	
5. SEX Female	6. COLOR OR RACE White	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) Widow	8. DATE OF BIRTH Feb. 16, 1886 69 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) floor lady		10b. KIND OF BUSINESS OR INDUSTRY Jacob's Bros.	
11. BIRTHPLACE (State or foreign country) Stevensville, Md.		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME Wilson Palmer		14. MOTHER'S MAIDEN NAME Lottie ---	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If year, give war or dates of service)		16. SOCIAL SECURITY No. 212 05 7801	
17. INFORMANT AND ADDRESS Mrs. Louis Respass, 814 Woodington Rd			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 171X Immediate cause (a) basinoma of cervix with metastases Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)			2 yrs
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	
HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Jan 12, 1955 to Jan 23, 1955 , that I last saw the deceased alive on Jan 23, 1955 , and that death occurred at 8 10 m., from the causes and on the date stated above.			
SIGNATURE [Signature]		ADDRESS [Signature] DATE SIGNED 1/25/55	
23. BURIAL, CREMATION REMOVAL (Specify) Burial		DATE 6/27/55	
NAME OF CEMETERY OR CREMATORY Loudon Park		LOCATION (City, town, or county) (State) Baltimore Md.	
DATE REC'D BY LOCAL REG. June 25 1955		REGISTERAR'S SIGNATURE R.W.	
24. FUNERAL DIRECTOR Harry H. Witke		ADDRESS 4101 Edmondson Ave	

MARGIN RESERVED FOR BINDING

